



## LICENSEE MANDATORY REPORTING FORM

Pursuant to Business and Professions Code (Code) sections 2878.1 and 4521.2, a licensed vocational nurse (LVN) or psychiatric technician (PT) is required to report another LVN or PT who is in violation of, or has violated, any of the statutes or regulations administered by the Board of Vocational Nursing and Psychiatric Technicians (Board). The report shall be made in writing within 30 calendar days of becoming aware of the violation. The reporting licensee shall fully cooperate with the Board in furnishing information or assistance as may be required. No person shall incur any civil penalty as a result of submitting any required report (*Code sections 2878.1 (e) and 4521.2 (e) and Civil Code Section 43.8*).

### LICENSEE REPORTING INFORMATION

Full Name	First	Last
License Number		
Resident Address	Street Address	City State Zip Code
Business Name or Employer		
Business or Employer Address	Street Address	City State Zip Code
Telephone Numbers	Home: ( )	Work: ( ) Cell: ( )

### LICENSEE COMMITTING VIOLATION(S)

Name of Licensee Committing Violation(s)	
License Number	
Business Name or Employer	
Business or Employer Address	Street Address City State Zip Code
Telephone Numbers	Home: ( ) Work: ( ) Cell: ( )

***Please mark all applicable boxes that best describe the violation(s) committed:***

- |   |   |
|---|---|
| <input type="checkbox"/> Incompetence or gross negligence                                   | <input type="checkbox"/> The commission of any act involving dishonesty, when the action is related to the duties of the licensee |
| <input type="checkbox"/> Use of excessive force or mistreatment of a patient                | <input type="checkbox"/> The knowing failure to provide infection control guidelines  |
| <input type="checkbox"/> Illegal use of controlled substances or alcohol                    | <input type="checkbox"/> Illegal possession, prescribing, or self-administration of controlled substances                         |
| <input type="checkbox"/> Falsification of medical records                                   | <input type="checkbox"/> Other (please describe): _____   |
| <input type="checkbox"/> Arrested or convicted of a criminal offense                        |   |
| <input type="checkbox"/> Failure to maintain confidentiality of patient medical information |   |

### LOCATION AND DATE(S) OF VIOLATION(S)

Location of Violation	Hospital Home Other _____
Business Name (If applicable)	
Address Violation Occurred	Street Address City State Zip Code
Date(s) Violation Occurred	

## DESCRIPTION OF INCIDENT

*(Please use additional sheets, if necessary.)*

## WITNESS INFORMATION

*If there were any witnesses to the violation, please provide the following information for each witness:*

Witness #1 Name:	Witness #2 Name:	Witness #3 Name:
Title:	Title:	Title:
Phone #:	Phone #:	Phone #:
Business:	Business:	Business:
Address:	Address:	Address:

## VIOLATION REPORTED TO OTHER INDIVIDUALS OR ENTITIES

*If the violation(s) was reported to another individual or entity, please provide the following information for each individual or entity:*

Name:	Name:	Name:
Phone #:	Phone #:	Phone #:
Date Reported:	Date Reported:	Date Reported:
Action Taken:	Action Taken:	Action Taken:

## ATTACHMENTS

*Please attach all available supporting documentation.*

*I certify under penalty of perjury under the laws of the State of California that to the best of my knowledge the foregoing information is true and correct and that any documents attached are true copies. I am aware that, if any statements made by me are knowingly false, I may be subject to punishment.*

Signature \_\_\_\_\_

Date \_\_\_\_\_